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AUTHOR Gatz, Margaret; And Others
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ABSTRACT

The 1980's may be remembered as the decade of the older woman, due in part to demographics and also to public awareness heightened by the women's movement. If psychology is to exert a constructive force towards the optimization of mental health of older women, it is essential for psychologists to be aware of the limits of current knowledge and the role of stereotypes in shaping both knowledge and the lives of older women. Typical myths about older women focus on those dealing with financial status, institutionalization, mental and physical health, and sexuality. Individual differences among these women reveal the need for more diversity in intervention programs and more attention to individual needs. (JAC)

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Margaret Gatz
Cynthia Pearson
Max Fuentes

Department of Psychology
University of Southern California

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HEALTH AND MENTAL HEALTH OF OLDER WOMEN IN THE 1980S: IMPLICATIONS FOR PSYCHOLOGISTS*

Margaret Gatz, Cynthia Pearson, and Max Fuentes

Department of Psychology, University of Southern California

The 1980's may well be remembered as the decade of the older woman. Older women, especially those aged 75 and older, are the fastest growing portion of the U.S. population. According to the 1980 census, 11.3% of the population are 65 or older and, within this group, 60% are women. Furthermore, over 40% of women 65 and older are living alone. The median yearly income for women 65 and older, as of 1977, was $3,087. More than 2 million older women live below the poverty level, and older women living alone are overrepresented among this group.

Older women are currently emerging from the invisibility of past decades probably due to the convergence of two forces. First, the facts just alluded to constitute something of a demographic imperative. Moreover, older persons increasingly are assuming advocacy roles on behalf of their own quality of life.

Second, the women's movement has heightened public awareness of the concerns of women of all ages. The movement originally arose from younger women acting to achieve social change on behalf of their own generation. Moreover, the movement questioned the value of traditional women's roles, and most women now old have led just such lives. By the mid 1970's, older women had been identified as the group that had been "left out" of the liberation, and efforts were underway to remedy this omission.

Still, as Abu-Leban wrote in 1981, "ageism and sexism, while often joint concerns of socially conscious women, offend and arouse different segments of the population."

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*Presented at Western Psychological Association, Sacramento, 9 April 1982. This paper reflects work in progress and describes our line of thinking. A more complete version will appear in Women and Society: A Community Psychology Perspective, edited by Annette Rickel, Meg Gerrard, and Ira Iscoe, and published by Hemisphere.

So it is not clear whether we are seeing a convergence of interest or the emergence of a new constituency. In any event, organizations such as the National Action Forum For Older Women and the Older Women's League have come forth as strong advocates for older women's issues. Last November there was a White House Conference on Aging. Among the mini-conferences that preceded the November meeting, there was a mini-conference on older women, titled "growing numbers, growing force." At the conference in November the concerns of older women occupied one of the fourteen committees. Their report was titled "growing numbers, special needs."

Particularly recently, quite a lot has been written about aging women. In that literature, much space has been given over to challenging commonly held myths and stereotypes about older women, stereotypes that have deleterious effects; but the challenge is almost of the nature of a countermyth. If psychology is to exert a constructive force towards the optimization of mental health of older women, it seems essential that we be aware of the limits of our current knowledge base and the role that myth plays in shaping both the knowledge base itself and the lives of older women. The tack we are taking therefore is to spell out for a number of key topics the myth, the countermyth, and the kernel of truth.

Before moving into those I need to mention two considerations that good gerontologists always mention. The first is the matter of cohort: What is true for my mother may not be true for me when I am 69. Thus, you will note that we use the expression "women now old."

The second is the matter of diversity. Older persons are not all alike. Indeed, older persons are more different from one another than younger persons are different from one another. This consideration leads me to an apology. Just as the foreword of books used to note that the masculine pronoun would be used throughout to denote both "he" and "she", I want to note that I will be referring throughout this report to "older persons" or to "women now old" or to "they." The term "they" should be taken to

denote diversity and to include a recognition that "we" will, in time, be "they."

1. The Poor Old Woman

Myth: The typical older adult lives in poverty.

Countermyth:* The majority of older people do not have incomes below the poverty level.

Kernel of Truth: Older adults, especially older women, are disproportionately poor. And I would submit that the majority of older people do worry about finances. Look at the agenda of the mini-conference on older women.

2. The Institutionalized Old Woman

Myth: Most older adults end up in institutions.

Countermyth: Only 5% of the aged are living in long-term care institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.). Following this line of reasoning, 95% of older adults are living in the community.

Kernel of Truth: These cross-sectional figures may be misleading. Three different studies have looked at death records in order to determine the likelihood of dying in a nursing home or long-term care facility (Kastenbaum & Candy, 1973; Lesnoff-Caravaglia, 1978; Ingram & Barry, 1977). The results have been 23%, 21%, and 30%, with more women than men dying in nursing homes and extended care facilities. Even these figures may underestimate the proportion of older adults who spend some period of time in a nursing home because they do not include terminally ill residents who were transferred to acute care hospitals.

To correct for this, one study reported on 10-year longitudinal data, from deceased residents of Alameda County, California, who were aged 55 and older at the start of the study (Vincente, Wiley & Carrington, 1979). Of 455 cases, 38.9% had resided in a convalescent or nursing home at least once before death. Women and persons living alone were more at risk for institutionalization .

*The first four countermyths are adapted from a well-known quiz on facts of aging (Palmore, 1977).

3. The Sick Old Woman

Myth: Most older adults have multiple health problems.

Countermyth: About 80% of the aged are healthy enough to carry out their normal activities.

Kernel of Truth: Only 14% of noninstitutionalized older adults are free of chronic illnesses (such as arthritis, heart disease, stroke, visual impairment, injury due to falling).

4. The Senile Old Woman

Myth: The majority of old people become senile (i.e. defective memory, disoriented, or demented).

Countermyth: a) Senile dementia is a disease. Prevalence of senile dementia for those age 65 and older is 5-7%. Prevalence is not significantly different for the two sexes. b) For the normal older adult, there is little decrement in intelligence, especially overlearned, verbal, crystallized intelligence (Schaie, 1975).

Kernel of Truth: a) Of those reaching age 80, from 20-25% can expect to have moderate to severe senile dementia. b) Declines in IQ with age have consistently been demonstrated, although IQ may not be predictive of anything useful (Botwinick, 1975). Also, there is a general slowing (Birren, 1977).

5. The Crotchety Old Woman

Our first try:

Myth: Cantankerous

Countermyth: Tranquil

These are two images in tandem: First, the old woman as aggressive, cantankerous, dominating, and irritable; second, the old woman as the blue-haired model of kindly tranquility, serenely crocheting in her rocking chair or handing out cookies to neighborhood youngsters. The intimate relationship of these myths is shown in fairy

tale of Hansel and Gretel, where the two personae merge in the character of the witch. The gingerbread portrait, with its unmistakeable overtones of helplessness and childlike dependence, is clearly the more socially desirable.

The questions posed by these myths have to do with personality and psychsocial adjustment. What do we know about personality development in late life? And what constellation of personal characteristics contribute to successful aging? There has been little study of personality development in older women. What there is strongly adheres to women cast in the role of homemaker and nurturer and doesn't reflect the possibilities for alternatives we now envision. Most personality studies seem to support idea of consistency across the life-span (Neugarten, 1977). The main emphasis on discontinuity seems to revolve around the mid-life crisis. In older women, two major changes seen: (1) increased interiority (introversion or introspection) and, (2) decreased sex-role-stereotyped behavior, which involves agentic, active mastery for women, including competitiveness, and ambition.

There are two points here: First, you are the same person as when you were younger. The second has to do with getting in touch with the other half (Neugarten, 1977).

restatement:

Myth: Hansel and Gretel

Countermyth: Androgeny

Kernel of Truth: To be arranged

6. There is also a myth about transitions, like "empty nest" and widowhood. The Kernel of Truth includes several points:

First, distress* seems more characteristic of midlife than of older women. As one indicator, suicide peaks at 55 for women and at 65 for men. An interpretation might be that the distress relates to transition into an undefined, insecure role. Midlife is the time when women are more likely to be concerned about re-entry into the labor force, loss of physical attractiveness, and other identity sorts of questions not of

*Indeed, the Depressed Old Woman may be the mental health myth.

concern to older women. Rather the older woman may experience some freeing from roles, and become a "truth teller."

Second, part of the myth is that transitions (like physical health) tend to be presented as losses. The Kernel of Truth needs to include the notion that these transitions are not discrete life events or stresses or losses, but are transitions to something else.

7. The Lonely Old Woman

Myth: Because they live alone, they are isolated, and they feel lonely.

Countermyth: Being alone doesn't necessarily mean that one is lonely, besides which, older women have lots of social contact.

Kernel of Truth: Living alone does not necessarily mean that one is isolated, but one may feel lonely.

8. The Sexless Old Woman

We're going to let Dear Abby (1981) pose this one:

> Dear Abby: My husband has been reading up on the subject of sex, and he is of the opinion that if a woman doesn't enjoy sex right up to the grave, there must be something wrong with her.
>
> At age fifty, and after thirty years of marriage, I would like to forget about sex altogether. Believe me, I've paid my dues.
>
> Where is it written that a woman should be ready and willing to perform every time her man beckons? I suspect that many (if not most) women get very little physical satisfaction out of sex; they just go through the motions...
>
> I can't believe that I'm the only woman who feels this way. Please poll your readers... Tired in Lincoln, Neb. (p. 88)

More on the side of the

Myth: "Thanks for asking for this survey. I thought I was the only fifty-year-old woman who was tired of sex. I'm also tired of cooking." Winnipeg, Can. (p. 92)

Countermyth: "This is the best time of my life!" Happy in Denver (p. 90)

"I've been a widow for twelve years. My husband and I both enjoyed sex until

he died. He was ninety. I could still enjoy it, but who would have me?" June, Age Eighty-one (p. 90)

Kernel of Truth:

Dear Abby reported that it divided about equally, and other, more scholarly sources concur that from 40% to much higher cease sexual activity. The most important message to my way of thinking is not to lay either stereotype on people.

In planning mental health interventions, these myths represent considerations to take into account. Moreover, they would seem to point to a population, that if not in distress, is at least one that psychologists would define as in need of preventive mental health services. Yet, the mini-conference on older women included no workshop devoted to mental health, and one must strain to find mental health among the recommendations of the committee on older women from the White House Conference.

Service use statistics back up this impression: older adults account for 15% of visits to physicians's offices, 34% of days in short-term hospitals, 89% of residents of long-term care nursing homes, 4% of clients of community mental health centers, and 2.7% of services rendered by psychologists. Older women are more likely than older men to see physicians and to use preventive health services.

It would seem that we need to take seriously some of the rhetoric such as: non-traditional services, outreach, increasing options, supporting not supplanting, minimal intervention, and the development of coherent service policies. Examples at three levels of intervention: (1) In terms of broad social agendas, we endorse the perspective of the Gray Panthers--youth and age working together. Also Jacqueline Jackson emphasizes the link between conditions of the pre-aged and the aged. (2) In prevention, one intervention might be training peer counselors and facilitating self-help, while being careful not to render unnatural the natural support system. (3) In the more traditional arena, particularly important is responding to requests to figure out what's wrong with momma (usually it is some combination of organic and functional) and what to do about it.

We are saying that we need to consider modest programs and a diversity of interventions. This diversity reflects the diversity of older women. Each person brings a unique combination of myths, countermyths, and kernels of truth, and we must be attuned to each individual's definition of what she needs:

> Dear Abby: "I am a widow, living alone on a pension. I have arthritis, diabetes, high blood pressure, and dizzy spells. My problem is that I have birds nesting in my drainpipe." Irma (p. 135)

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